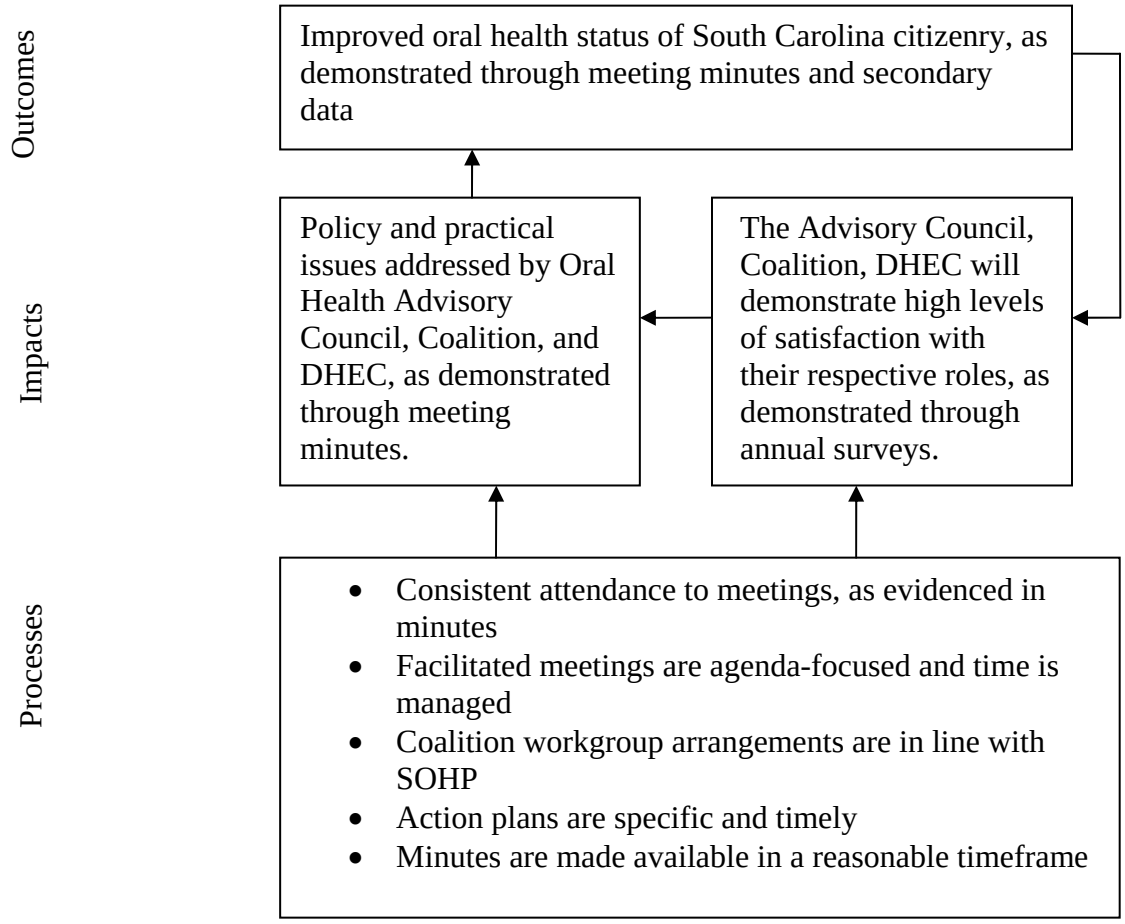
Advocacy and Policy

Background - It was emphasized repeatedly during the National Governor's Association Policy Academy in 2000 and subsequent state oral health summits that the most critical aspect of the state's response to the silent epidemic of dental disease is to assemble a group of high profile stakeholders to guide the process of increasing recognition of oral health issues among policy makers and the public. As former US Surgeon General stated in his 2000 Report on Oral Health in America, we should "change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health."

Logic Model –



Objectives:

1.1. Establish a Coalition and Advisory Board structure that promotes coordination and facilitative communication by September 2006.

Healthy People Reference 7-11u Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to oral health Baseline (1996-97): 25% 2010 Target: 50%
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 (See Appendix A)
Measurement Type - Process
Data Collection Method – DHEC Oral Health Division staff will collect standardized meeting minutes on a quarterly basis and track progress based on the information collected through them.. The proposed meeting minute template is in Appendix B.

1.2. Conduct quarterly advisory summits (QAS) that contain 3 parts: (a) preliminary joint session of Advisory Council and Coalition to raise policy and practice issues for 30 minutes; (b) Advisory council and coalition split for 1 hour so that the former addresses policy issues and the latter reports on their activities; (c) wrap up joint session for action plans to be agreed upon for 30 minutes.

Healthy People Reference 7-11u Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to oral health Baseline (1996-97): 25% 2010 Target: 50%
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 (See Appendix A)
Measurement Type - Process
Data Collection Method – DHEC Oral Health Division staff will collect standardized meeting minutes on a quarterly basis and track progress based on the information collected through them.. The proposed meeting minute template is in Appendix B.

1.3. Improve the satisfaction of Advisory Council, Coalition, and DHEC staff with their respective roles by September 2007

Healthy People Reference 7-11u Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to oral health Baseline (1996-97): 25% 2010 Target: 50%
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 and 1.2 (See Appendix A)
Measurement Type - Impact
Data Collection Method – An outside evaluator will conduct a satisfaction survey (to be developed) on an annual basis.

1.4. Improve the speed with which the Advisory Council and Coalition are able to address and resolve policy and practical issues in oral health by September 2007

Healthy People Reference - Not applicable
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 and 1.2 (See Appendix A)
Measurement Type - Impact
Data Collection Method – DHEC Oral Health Division staff will collect standardized meeting minutes on a quarterly basis and track progress based on the information collected through them. The proposed meeting minute template is in Appendix B.

1.5 Improve the overall oral health status of South Carolinians (of all ages) through advocating policies that promote oral health by September 2007.

Healthy People Reference - 7-11w Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to surveillance and data systems Baseline (1996-97): 14% 2010 Target: (developmental)
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 and 1.2 (See Appendix A)
Measurement Type - Outcome
Data Collection Method – DHEC Oral Health Division staff will collect standardized meeting minutes on a quarterly basis and track progress based on the information collected through them. The proposed meeting minute template is in Appendix B.

1.6. Conduct annual statewide Oral Health Forum in order to educate the Advisory Council, Coalition, Division of Oral Health, and other key stakeholders on emerging public oral health and dental care issues.

Healthy People Reference 7-11u Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to oral health Baseline (1996-97): 25% 2010 Target: 50%
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 (See Appendix A)
Measurement Type - Process
Data Collection Method – Evidence of the annual forums include registrations, agenda, and other support documentation.

1.7. Assist the Advisory Council and Coalition in planning, implementation, and evaluation of the State Oral Health Plan.

Healthy People Reference 7-11u Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs, with regards to oral health Baseline (1996-97): 25% 2010 Target: 50%
Original State Oral Health Plan Reference – Priority 1, Strategy 1.1 (See Appendix A)
Measurement Type - Process

Data Collection Method – Evidence of meeting minutes and evaluation products.

Comments:

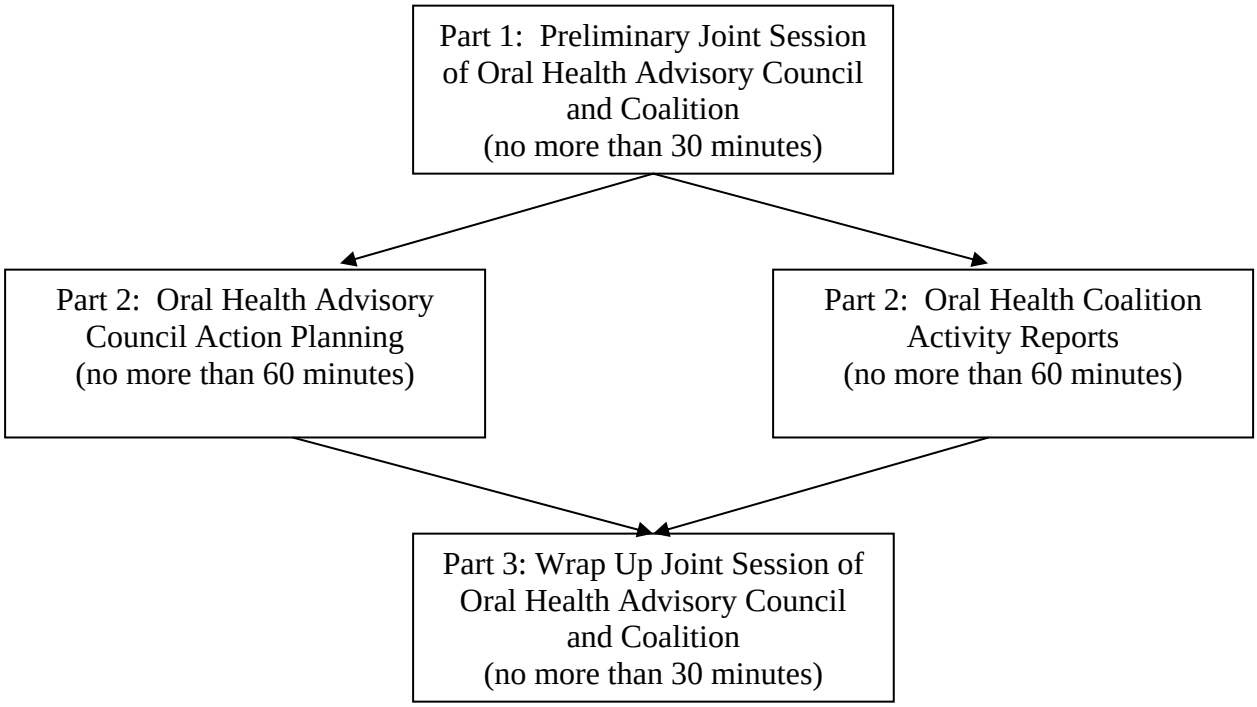
Organizational & Process Issues

The Oral Health Advisory Council and Coalition have historically made demonstrable contributions to DHEC's Division of Oral Health. There have recently been, however, noted communication and coordination challenges among the three entities. Given the utility of each group, there is tremendous value in using the strengths of each group in furthering public oral health in South Carolina. An enhanced strategy, delineated in this section, is proposed based on meaningful feedback given by Coalition members at several evaluation planning venues.

The Coalition recognizes the political expertise each Advisory Council member and would like to see them used more effectively and in concert with the practical and policy issues they see in the oral health field. This spirit of coordination has been articulated consistently at evaluation planning meetings in the Fall of 2005 and Winter of 2006. Based on Coalition recommendations and noted communication and coordination challenges, a proposed advisory structure and process is presented here.

Proposed Advisory Structure and Process

Effective September 2006, it is proposed that the Advisory Council and Coalition will have quarterly advisory summits (QAS). These meetings will be no more than 2 hours in length and will be facilitated by Division of Oral Health staff. The structure is advisory process and structure is presented in the figure below:



PART 1: It is proposed that the initial 30 minutes of the meeting agenda be dedicated to integrating the Advisory Council and Coalition with the specific purpose of identifying policy and practical issues that need addressing by the entities. Specific agenda items could include:

(1) the Advisory Council sharing their knowledge of federal and state policies that are currently, or will, impact oral health care in South Carolina.
(2) The Coalition sharing their concerns about practical and policy issues they are facing in the field.
(3) The establishment of a policy priority list for the upcoming quarter achieved through consensus among the two groups.

It is important to note here that policy does not necessarily mean legislation. Policy may be in the form of recommendations from relevant advocacy groups such as the Dental Association, Primary Care Association, Public Health Association, just to name a few. Meeting minutes and facilitation will be provided by the Division of Oral Health

PART 2: Once the policy priority list is established, the two groups will split for individualized meetings lasting not more than one hour. The Advisory Council will address the policy priority list by developing an Action Plan at each meeting. The Action Plan will consist of three core components:

(1) Suggestions on what they (Advisory Council) can do within their purview of influence to further the policy priority item(s) and deadlines for action.
(2) Suggestions on what the Coalition members can do to mobilize and address the policy agenda item(s) and deadlines for action.
(3) Suggestions on what the Division of Oral Health can do to address the policy priority item(s) and deadlines for action.

A member of the Division of Oral Health staff will facilitate and keep minutes of the Advisory Council meeting.

Simultaneously, the Coalition will conduct their own meeting specific to updating its membership on its workgroup activities that are directly related to the State Oral Health Plan (SOHP). The workgroups will need to be revamped so that they are organized similarly to the SOHP, which also will need to be revised so that it better reflects the priorities of Division of Oral Health's evaluation plan and the state's oral health agenda. The workgroups will meet and engage in their activities at their own times prior to the QAS. As with the Advisory Council's meeting, the Division of Oral Health staff will take minutes and provide facilitation.

PART 3: For the remaining 30 minutes of the QAS, the Advisory Council and Coalition will reconvene for the purpose of debriefing the Action Plan for the policy priorities. Advisory Council members will share their recommendations of action with discussion facilitated by Division of Oral Health staff. Minutes will be taken so that there is an official record of the priorities, action plans for each entity, and deadlines. The minutes from Part 3 of the QAS will serve as the agenda item for the next QAS. Therefore, Part 1 of the subsequent QAS will lead off with an update from the previous QAS's Action Plan with the establishment of a new priority list. It is likely some items will be

recurring, however, this process provides an information feedback loop to all key stakeholders.

Evaluation Relevance

The minutes from the QAS will serve as a key qualitative data source for the evaluation of the advisory portion of the state's public oral health program. With the proposed structure and process, there is fluidity and stability in the agenda with appropriate tracking of follow-up. Additional quantitative data will be a component as well as policy issues are addressed. For example, it may become necessary to look at Medicaid utilization if reimbursement issues are addressed. There are several objectives suggested for the advisory capacity component of the evaluation, as demonstrated in the draft logic model below:

Summary

The proposed advisory structure and process is intended to make the best use of the key stakeholders' time and talents. It is intended to improve communication and coordination among all the entities, while maximizing the thin capacity currently experienced by the Division of Oral Health. It is proposed that the new advisory structure and process will be implemented beginning in September 2006 in order to provide a period of transition as Coalition workgroups are reorganized and centered around the SOHP and evaluation effort. Your feedback in this process is sincerely requested.